

12976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sussexville</u>		c. LENGTH OF STAY IN 1b <u>5m</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kidney Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>W. Walter Arrington</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (United) Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In Queenstown Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Perry Arrington</u>		14. MOTHER'S MAIDEN NAME <u>Emily Musser Serere</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr C P Arrington</u>		Address <u>Croftville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Decomposition</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Asthma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>7:19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> 19 <u>57</u> , to <u>July 23</u> 19 <u>60</u> , that I last saw the deceased alive on <u>July 22</u> 19 <u>60</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1014 E. 1st St. Salisbury Md</u> DATE SIGNED <u>July 11/60</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. [Name]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 26 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Church</u>		22d. LOCATION (City, town, or county) (State) <u>In Queenstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Antietam Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - CHICAGO, ILL.

1912

Form with multiple lines for handwritten entry, including fields for name, date, and cause of death.

13003

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>		c. LENGTH OF STAY IN 1b <b>(6 Years)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Davis Nuring Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
f. STREET ADDRESS <b>High St.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Belding</b> Last <b></b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>16,</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1868</b>
9. AGE (In years last birthday) yrs. <b>92</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>	
11. BIRTHPLACE (State or foreign country) <b>Troy New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rufus E. Belding</b>		14. MOTHER'S MAIDEN NAME <b>Martha B. Seymour</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-20-8016</b>	
17. INFORMANT <b>Anson Belding</b>		Address <b>227 School St. Watertown, Mass.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Parabolic Decompression</b> DUE TO <b>Paul Belding</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO <b>Ephing Scurvy</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month <b></b> Day <b></b> Year <b>1960</b> Hour a. m. <b></b> p. m. <b>7:15</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I attended the deceased from <b>July 16, 1960</b> to <b>Nov 16, 1960</b> , that I last saw the deceased alive on <b>Nov 15, 1960</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sudlersville, Md</b> DATE SIGNED <b>11/17/60</b>			
ACTUAL SIGNATURE <b>C. H. Metcalfe</b>		M.D. <b></b>	
PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 19, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO HO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13004

CERTIFICATE OF DEATH

Reg. Dist. No.

12978

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X STEVENSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frances Chance</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>FEM</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 6 - 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JOSHUA KNOTTS</b>			
14. MOTHER'S MAIDEN NAME <b>Sara Harris</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>MR. CHANCE - STEVENSVILLE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>170.9</b> DUE TO <b>Malignant Melanoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>OCT</b> , 19 <b>58</b> , to <b>Nov.</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 3</b> , 19 <b>60</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Irvin G. Hoyt</b>				ADDRESS (Street, city or town, state) <b>Queenstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Irvin G. Hoyt MD</b>				DATE SIGNED <b>11/9/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 11</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENMONT</b>		22d. LOCATION (City, town, or county) (State) <b>HILLSBORO MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				ADDRESS <b>Church Hill Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							





## CERTIFICATE OF DEATH

Reg. Dist. No.

12979

13005

1. PLACE OF DEATH a. COUNTY <b>Queen Annes</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Rural Millington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown. Rural Millington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>A.</b> Last <b>Goldsboro</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Harkless</b>				14. MOTHER'S MAIDEN NAME <b>Maria Baynard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>James B. Goldsboro, 17 Center St. New, Castle, Del.</b>				Address <b>Hamilton Park,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fall &amp; Exposure</b> DUE TO <b>902.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Actual Polio</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pachy</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fall from chair on bus porch</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. m. <b>19</b> p. m. <b>1960</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Millington, Md.</b>		20g. (County) <b>Queen Anne</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Nov 19</b> , 1960, to <b>Nov 24</b> , 1960, that I last saw the deceased alive on <b>Nov 22</b> , 1960, and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. H. Metcalfe</b>				M.D. <b>Sub. Anesth. Ref.</b>			
PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe.</b>				DATE SIGNED <b>11/25/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery,</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Millington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Holloway, Millington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**13006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12980

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wiconico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>G.</b> Last <b>HOLBROOK</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1934</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Holbrook</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Wright</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 4/4/57-10/25/57</b>				16. SOCIAL SECURITY NO. <b>220-28-2692</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off oyster dredge boat</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11/9</b> 19 <b>60</b> p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) (County) (State) <b>Queen Anne Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/10/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/60</b>		22c. NAME OF CEMETERY OR <del>burial place</del> <b>St. Charles Methodist</b>		22d. LOCATION (City, town, or country) (State) <b>Chance, Maryland</b>	
23. FUNERAL DIRECTOR <b>L. G. Webster</b>				ADDRESS <b>Princess Anne, Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. King</b>			

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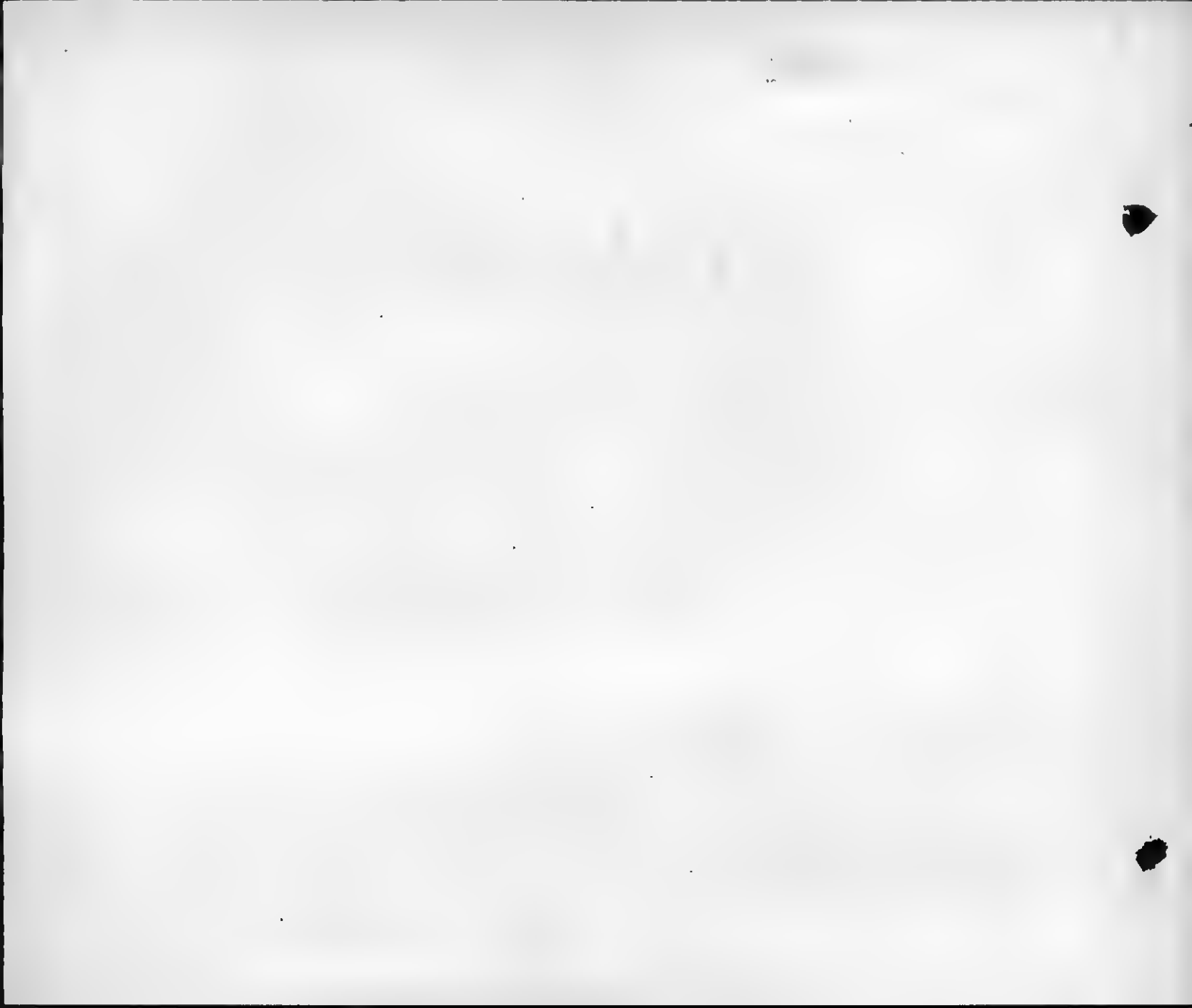
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>16112</u>				e. STREET ADDRESS <u>Centerville Heights</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GLADYS REBECCA KEITH</u>				4. DATE OF DEATH Month Day Year <u>Nov 16 1960</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26-1888</u> 72 yrs	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
		Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>in Centerville Maryland</u>	
13. FATHER'S NAME <u>John Juster</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO		17. INFORMANT <u>J W Keith</u> Address <u>Centerville Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u>							<u>1 day</u>
DUE TO (b) <u>Far advanced Arteriosclerosis</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>37 years C.U.A.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 20 1957</u> to <u>Nov 16 1960</u> that I last saw the deceased alive on <u>Nov 12 1960</u> and that death occurred at <u>2 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1043 Lakeside Dr. W. H. H.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 22 1960</u>			
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 18 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christiansburg</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Baatman Baatman</u> ADDRESS <u>Centerville Md</u>				24a. REC'D BY REGISTRAR <u>NOV 22 60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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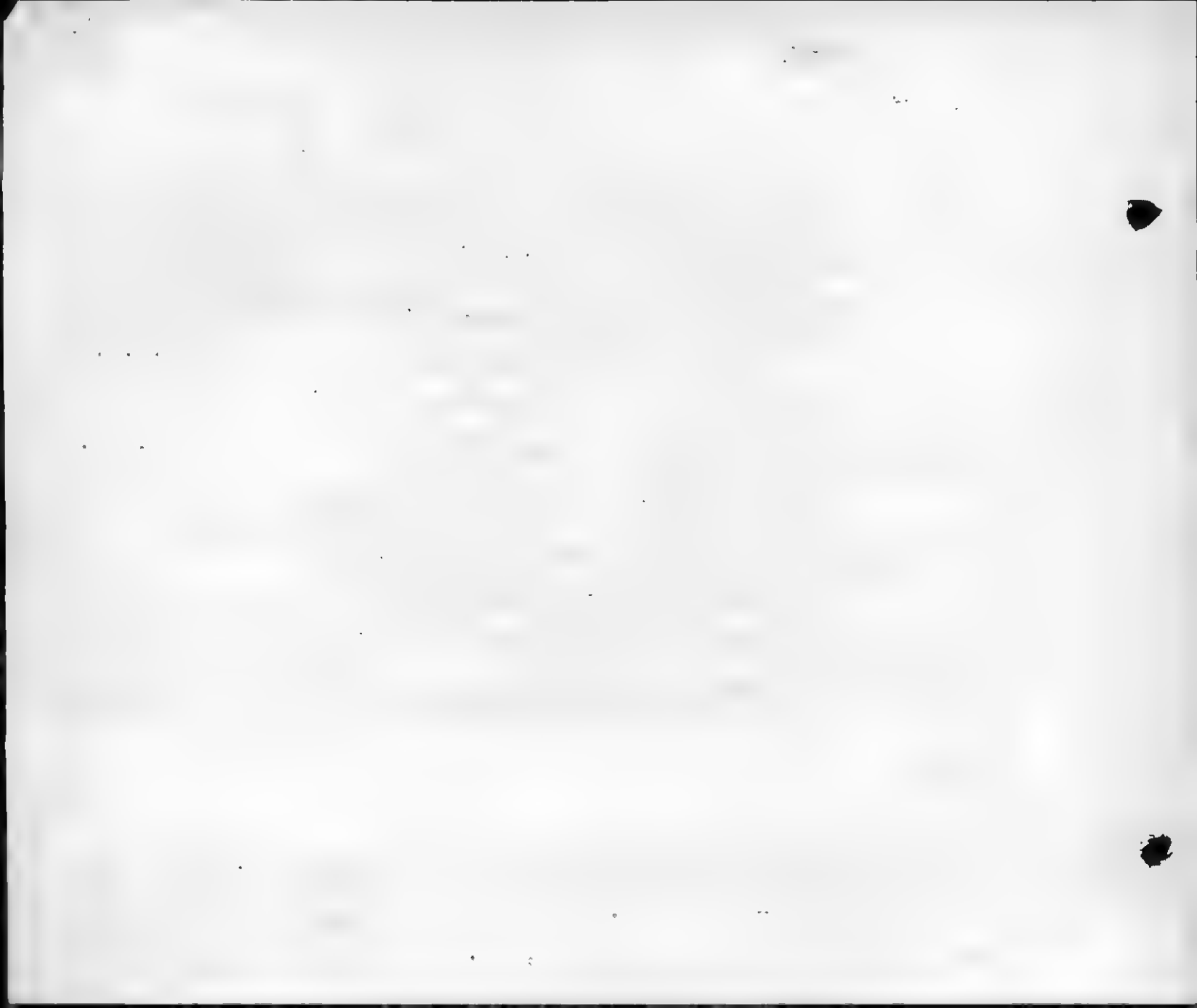
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12982

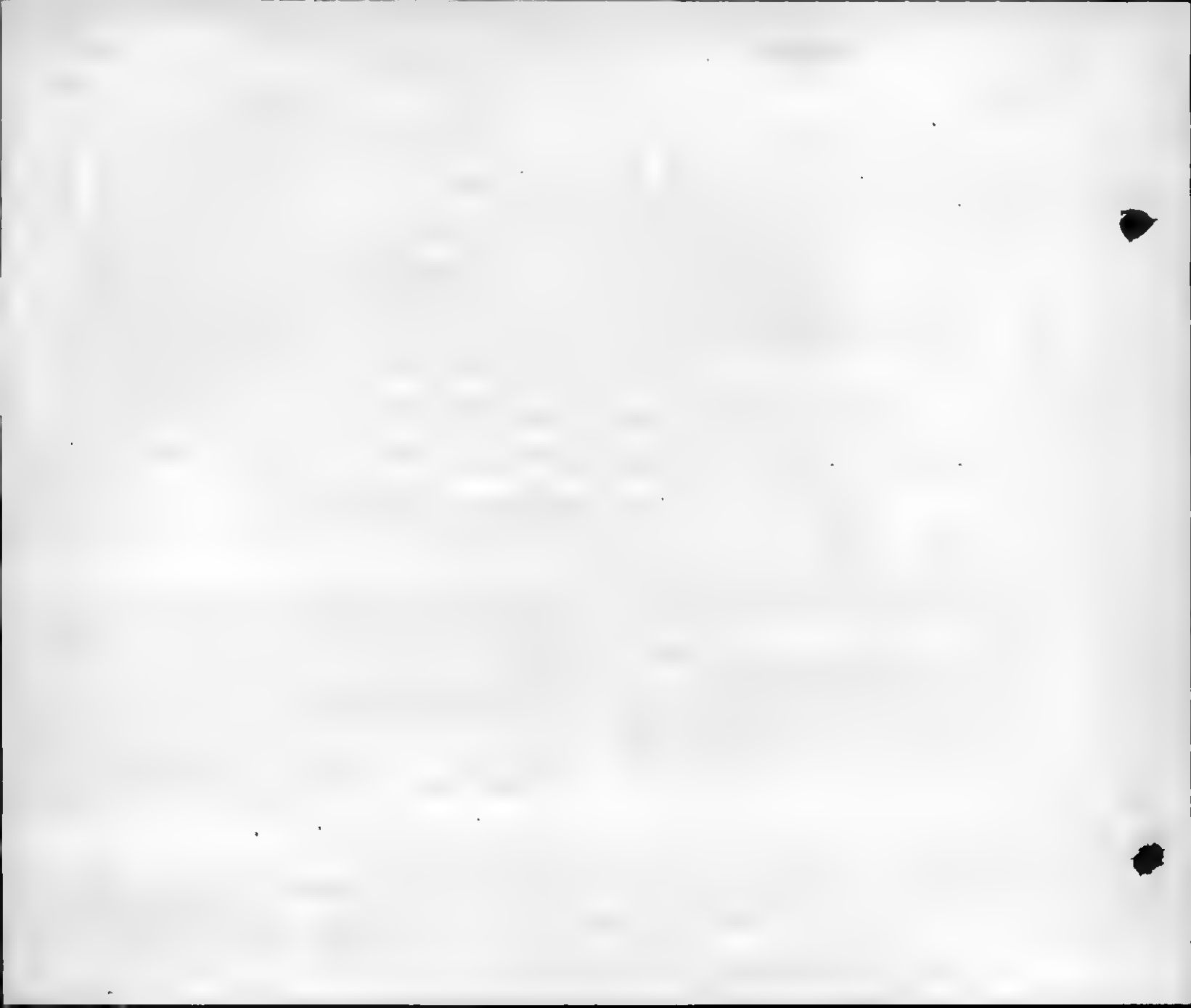
CHIEF OF STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Queen Ann</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Ann</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sudlersville</b>		c. LENGTH OF STAY IN 1b <b>84</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sudlersville</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>	
e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Norton</b> Last <b>Kilson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months <b>84</b> Days <b>27</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Kilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary ? Norton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Miss Edythe Jolley</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Disturbance</b> 4122-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Insulin</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>11</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 6, 1960</b> to <b>Nov 27, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 27, 1960</b> and that death occurred at <b>11 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. W. [Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Rural Sudlersville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City, town, or county) (State) <b>Marydel Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boulais</b>		ADDRESS <b>Greensboro, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

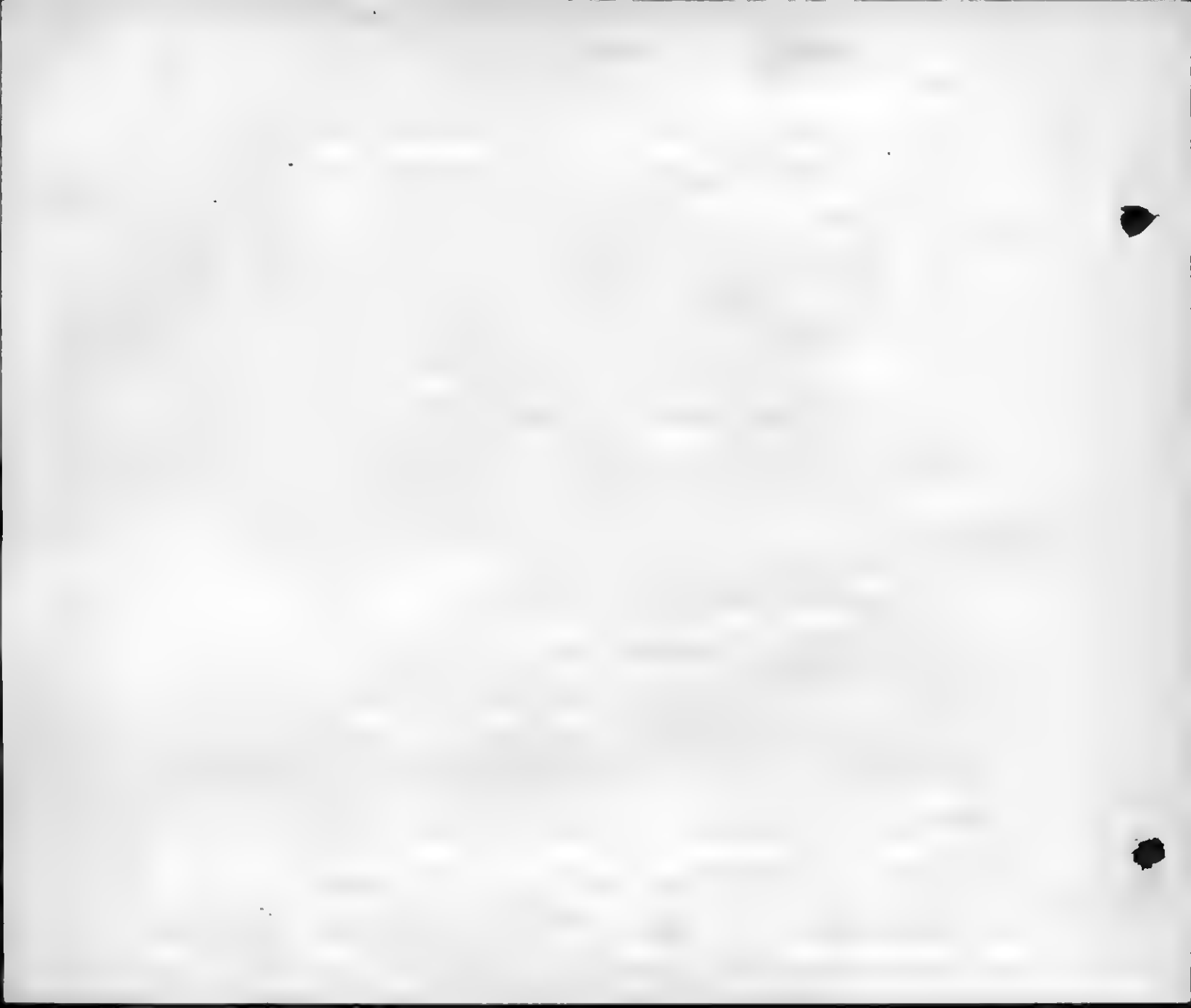
13001

## CERTIFICATE OF DEATH

Reg. Dist. No.

12984

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>115 Windsor Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>NEIGHBORS</u> Middle <u>NEIGHBORS</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>14</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30, 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE NEIGHBORS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARITA BECK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Robert Neighbors</u> Address <u>Centreville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> <u>3-4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , to <u>Nov. 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>60</u> , and that death occurred at <u>4 Am</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Smith, Jr.</u> M.D. <u>Centreville, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>
22d. LOCATION (City, town, or county) <u>17th St. Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Moore &amp; Son, Centreville, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	





may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13009

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

12985

1 PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home Kitty Blackiston Nursing</b>				d. STREET ADDRESS <b>High St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> ##							
3. NAME OF DECEASED (Type or print)		First <b>Milton</b> Middle Last <b>Pinder</b>		4. DATE OF DEATH <b>Nov. 8, 1960</b>		Month Day Year	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Apr. 1, 1907</b>		9. AGE (In years last birthday) <b>53</b> yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Pinder</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Blaghton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-16-7012</b>		17. INFORMANT <b>Caroline Pinder</b> Address <b>Sudlersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO <b>Cerebral Hemorrhage</b>							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarct</b> DUE TO <b>Stroke</b>							
(c) <b>old hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary artery disease 1957</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year. Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1, 1907</b> to <b>Nov 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 8, 1960</b> and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>C. H. Metcalfe</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		11/10/60 22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>		22d. ADDRESS <b>Sudlersville, Md.</b>					
23a. BURIAL CREMATION <b>Burial</b>		23b. DATE THEREOF <b>Nov. 11, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. D. S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12986

Reg. Dist. No.

13010

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>O.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. LENGTH OF STAY IN 1b <u>7yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wesley</u> Last <u>Schall</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1902</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Schall</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Mrs. Mary Lee</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Four min.</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/30/60</u>	
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carter, EASTON, MD.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13011

## CERTIFICATE OF DEATH

12987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL MILLINGTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL MILLINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>ELEANOR</b> First <b>WALLS</b> Middle <b>WALLS</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 27-1871</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>RICHARD LEGAR</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE SCOTTEN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		INFORMANT Address <b>MRS. NAN BIDDLE SUDLERSVILLE</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Route 1 Cardiac Arrest</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Arterial Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Herpes Zoster of Forehead - Scindly</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>7:00</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>58</b> , to <b>Nov 25</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Nov 25</b> , 19 <b>60</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. H. METCALFE</b>			ADDRESS (Street, city or town, State) <b>@ 1701 E. Calfe M.D. Sudlersville, Md.</b>			DATE SIGNED <b>11/26/60</b>	
PHYSICIAN'S NAME (Type) <b>C. H. METCALFE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 28</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CRUMPTON</b>		22d. LOCATION (City, town, or county) (State) <b>CRUMPTON MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar D. Lane</b>			ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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